Application Checklist for Speech-Language Pathologists and Audiologists

Required Professional Experience

(US Graduates)

Items 1-3 are required for issuance of the temporary license. PRIOR APPROVAL IS REQUIRED. *NOTE: DOJ and FBI* ***clearances*** *must be received prior to issuance.*

1. **Application for Temporary Licensure (pages 1 – 4)**

2. **License Fees**
   - Check or Money Order for $60 made payable to SLPAHADB.

3. **Fingerprints**
   - California applicant must use Livescan; send copy of your form to the Board. Fees paid directly to Livescan Operator.

   - If out-of-state, send two fingerprint cards (FD-258) and $49 to cover DOJ and FBI. You may submit one check or money order in the amount of $109.

Items 4-7 must be submitted within 30 days of issuance of your temporary license.

4. **Transcripts – Graduate Programs only**
   - Sent directly from the universities.
   - Master's Degree for Speech-Language Pathology applicants.
   - Doctorate Degree for Audiology applicants.

5. **Copy of Degree**
   - If not posted on transcript.

6. **Clinical Practicum**
   - Must be on our form and mailed directly to the Board from the university.

7. **National Exam Score**
   - Effective 09/01/2014 minimum passing score of 162 – SLP
   - Effective 01/01/2013 minimum passing score of 170 - AU
   - Must be within five years.
   - Must be sent electronically from Praxis to our Board.

8. **RPE Verification Form**
   - Submit a separate verification form for each public school year.
   - Provide a calendar for each school year.
   - Letter from the school district defining the dates and hours of the summer session.

9. **Permanent/Full Licensure Application**
   - No additional fees are required.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY& HEARING AID DISPENSERS BOARD
2005 EVERGREEN STREET, SUITE 2100, SACRAMENTO, CA 95815
PHONE (916) 263-2666 FAX (916) 263-2668 WWW.SPEECHANDHEARING.CA.GOV

REQUIRED PROFESSIONAL EXPERIENCE (RPE) APPLICATION
TEMPORARY LICENSE
$60.00

INSTRUCTIONS: Do not print this application double-sided. You must complete **Part A** and your supervisor must complete **Part B**. Any corrections to this form must be crossed out and initialed.

Please check applicable:

☐ Speech-Language Pathologist ☐ Audiologist

Professional services can only start upon the issuance of the RPE temporary license.

PART A – Personal Information

1. FULL LEGAL NAME: LAST FIRST MIDDLE
2. OTHER NAMES YOU HAVE USED (INCLUDING MAIDEN):
3. STREET ADDRESS:
CITY, STATE, ZIP CODE:
4. RESIDENCE TELEPHONE: BUSINESS TELEPHONE:
5. SOCIAL SECURITY NUMBER (SSN) OR INDIVIDUAL TAX IDENTIFICATION NUMBER (ITIN):
6. DATE OF BIRTH: (MM/DD/YYYY)
7. EMAIL ADDRESS:

ATTACH 2" x 2"
PASSPORT QUALITY PHOTOGRAPH
(Must be an actual photograph, not a paper copy.)

Photographs must be taken within 60 days of the filing date of this application.

Print your full name on the back of the photograph.

Notice: Effective July 1, 2012, the State Board of Equalization and the Franchise Tax Board may share taxpayer information with the Board. You are obligated to pay your state tax obligation and your license may be suspended if your tax obligation is not paid.

PART A - Continued	YES	NO
8. Have you taken the Educational Testing Service/National Teacher Examination (NTE) (The Praxis series) in speech-language pathology or audiology within the previous 5 years? ***Must have been completed in the United States.***	☐	☐
9. Have you completed any portion of your CFY/RPE in another state?	☐	☐
10. Have you ever been licensed to practice speech-language pathology or audiology in any state or country? If yes, what state(s) or country? _____	☐	☐

A <u>YES</u> answer to any of the questions below (11 through 16), requires you to complete and submit the Conviction and Discipline Reporting Form.

	YES	NO
11. Have you ever been the subject of a disciplinary action or have any *pending* disciplinary action taken or charges filed against any speech-language pathology, audiology, hearing aid dispensing, or other healing arts license? Include any disciplinary action taken by any other State or Federal Government Entity? *This includes but is not limited to suspension, revocation, probation, confidential discipline, consent order, letter of reprimand or warning, or any other restriction of actions taken against a license.*	☐	☐
12. Have you had any pending investigations by any State or Federal agencies against you?	☐	☐
13. Have you been denied a license to practice speech-language pathology, audiology, hearing aid dispensing, or other healing arts, in any state or country?	☐	☐
14. Have you voluntarily surrendered a license to practice speech-language pathology, audiology, hearing aid dispensing, or other healing arts in another state or country?	☐	☐
15. Have you been convicted of, or pled nolo contendere to **any** criminal offense, misdemeanor or felony of any state, the United States, its territories or a foreign country? *(This includes any citation, infraction, misdemeanor and/or felony, excluding violations of minor traffic laws not involving alcohol or drugs which result in fines of $300 or less. Note: Convictions that were later dismissed pursuant to Sections 1203.4, 1203.4a, or 1203.41 of the California Penal Code or equivalent non-California law **<u>must</u>** be disclosed. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b),(c),(d),(e), or section 11360(b) that are two years or older should **not** be reported).* *You must also submit a certified copy of any court order dismissing a conviction pursuant to Penal Code sections 1203.4, 1203.4a, or 1203.41.*	☐	☐
16. Are you required to register as a sex offender pursuant to section 290 of the Penal Code, or the equivalent in another state or territory, or military or federal law?	☐	☐

I hereby certify under penalty of perjury under the laws of the State of California that all statements made herein are true in every respect and that misstatements or omissions of material facts may be cause for denial of this application, or for suspension or revocation of a license.

APPLICANT'S SIGNATURE: _____ DATE SIGNED: _____

PART B – To be completed by the RPE Supervisor

Refer to Title 16, California Code of Regulations, Section 1399.153.3 for supervisor's responsibilities.

17. FULL LEGAL NAME OF SUPERVISOR: LAST FIRST MIDDLE

STREET ADDRESS:

CITY, STATE, ZIP CODE:

18. BUSINESS TELEPHONE: LICENSE NUMBER:

19. EMAIL ADDRESS:

20. PROPOSED START DATE:

AS SOON AS APPROVED _____ FUTURE DATE: _____

Professional services can only start upon the issuance of the RPE temporary license.

21. NUMBER OF RPE EMPLOYMENT HOURS PER WEEKS:

_____ 30-40 (FULL-TIME) _____ 15-29 (PART-TIME)

22. LIST OF PLACE(S) WHERE FUNCTIONS WILL BE PERFORMED:
(DO NOT PROVIDE CONTRACT AGENCY NAME AND ADDRESS)

_____
FACILITY OR SCHOOL NAME (DO NOT USE ABBREVIATIONS) ADDRESS CITY, STATE, ZIP CODE

_____
FACILITY OR SCHOOL NAME (DO NOT USE ABBREVIATIONS) ADDRESS CITY, STATE, ZIP CODE

_____
FACILITY OR SCHOOL NAME (DO NOT USE ABBREVIATIONS) ADDRESS CITY, STATE, ZIP CODE

23. IS THE SETTING(S) LISTED IN QUESTION #22 A PUBLIC SCHOOL?
YES ☐ NO ☐

IF YES, IS THE RPE:
☐ A SALARIED EMPLOYEE OF THE SCHOOL PUBLIC OR COUNTY OFFICE OF EDUCATION.
☐ PAID BY A CONTRACT AGENCY AND PLACED IN THE PUBLIC SCHOOL.

24. SUPERVISION:

☐ THE RPE WILL BE WORKING FULL-TIME AND I AGREE TO PROVIDE EIGHT HOURS A MONTH DIRECT SUPERVISION. FOUR OF THE EIGHT WILL BE IN SCREENING, THERAPY, AND EVALUATION.

☐ THE RPE WILL BE WORKING PART-TIME AND I AGREE TO PROVIDE FOUR HOURS A MONTH DIRECT SUPERVISION. TWO OF THE FOUR WILL BE IN SCREENING, THERAPY, AND EVALUATION.

I, the RPE applicant, have discussed the plan for supervision with this supervisor and agree to its implementation and will not provide professional services until I have been issued a RPE temporary license. I further certify under penalty of perjury under the laws of the state of California that all statements made in the application are true and correct. Any misrepresentation may be caused for denial of my license.

APPLICANT'S SIGNATURE: _____ DATE SIGNED: _____

I, the RPE supervisor, have discussed the plan for supervision with the RPE applicant and hereby accept professional and ethical responsibility for his or her performance. I understand that professional services cannot be rendered until a RPE temporary license has been issued. I further certify under penalty of perjury under the laws of the state of California that all statements made in part B are true and correct.

SUPERVISOR'S SIGNATURE: _____ DATE SIGNED: _____

REQUIRED PROFESSIONAL (RPE) TEMPORARY LICENSE

✦Duties and Responsibilities of Applicant✦

RPE temporary license applicants and applicant's supervisor must read and sign this form under the penalty of perjury. Please submit with the completed RPE application.

1) I have read and understand the excerpts of the laws and regulations, included with my application, pertaining to the responsibilities of an RPE temporary license holder.

2) My supervisor shall maintain a current license issued by the Board, during the time of my supervision. If my supervisor's license expires during the course of professional experience, I will immediately notify the board. *A supervisor's license may be verified at any time at the Board's website*.

3) I understand that my work plan can be 36 weeks of full-time professional experience (defined as 30-40 hours per week) with eight hours of direct supervision per month or 72 weeks of professional part-time professional experience (defined as 15-29 hours per week) with four hours of direct supervision per month.

4) If there is a break in professional experience due to a medical reason, it is my responsibility to notify the Board of the exact dates of the absence. I will not receive credit for the break in professional experience.

5) At the time of termination of supervision, I will ensure that my supervisor completes the RPE Verification form. I understand that it is my responsibility to submit the verification form within 10 days of completion.

APPLICANT SIGNATURE	PRINTED FULL LEGAL NAME OF APPLICANT	DATE

✦ Duties and Responsibilities of Supervisor ✦

1) I possess the following qualification to supervise an RPE applicant: a California SLP license; or (if employed by a public school) a clear, valid, teaching credential authorizing service in language, speech, and hearing issued by the Commission on Teacher Credentialing.

2) I agree to ensure that either my SLP California license or my teaching credential is renewed in a timely manner. Failure to do so could result in a loss of credit for professional experience by the RPE.

3) I agree to provide eight hours direct supervision per month for each full-time RPE (defined as 30-40 hours per week) and four hours direct supervision per month for each part-time RPE (defined as 15-29 hours per week).

4) I will not supervise more than three RPE's at any one time pursuant to California Code of Regulations Section 1399.153.4.

5) I will immediately notify the RPE of any disciplinary action, including revocation, suspension (even if stayed), probation terms, inactive licensure, or lapse in licensure that affects my ability or right to supervise.

6) I have read and understand the laws and regulations pertaining to the supervision of the RPE and the professional experience required.

7) I will ensure that the extent, type, and quality of the clinical work performed is consistent with the training and professional experience of the RPE and shall be accountable for the assigned duties performed by the RPE.

8) At the time of termination of supervision of the RPE, I will complete the RPE verification form. I will submit the original signed form to the Board within 10 calendar days of termination of supervision.

9) I have completed the initial six hours of continuing professional development in supervision training and will complete three hours every renewal cycle.

SIGNATURE OF SUPERVISOR	PRINT FULL LEGAL NAME OF SUPERVISOR	LICENSE NO.	Date

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CLINICAL PRACTICUM VERIFICATION

REQUIREMENTS:

A minimum of 300 clock hours must be completed in at least 3 different settings under the supervision of a licensed Speech-Language Pathologist or Audiologist.

A maximum of 25 hours may be obtained in a field other than that for which the applicant is seeking licensure. (For example: audiology for a speech-pathology applicant or speech-pathology for an audiology applicant.)

This form must be completed and submitted directly to the board by the training program director.
DO NOT USE WHTE OUT OR CORRECTION TAPE ON THIS FORM.

APPLICANT INFORMATION:

1. NAME LAST FIRST MIDDLE	
2. SOCIAL SECURITY NUMBER:	3. DATE OF BIRTH: (MM/DD/YY)

UNIVERISTY & TRAINING PROGRAM DIRECTOR INFORMATION:

4. COLLEGE OR UNIVERSITY:
5. PROGRAM DIRECTOR NAME:
6. LICENSE NUMBER OR ASHA CERIFICATION NUMBER:

VERIFICATION:

	YES	NO
7. THE APPLICANT HAS COMPLETED A MINIMUM OF 300 CLOCK HOURS OF SUPERVISED CLINICAL EXPERIENCE IN DIRECT CLIENT/PATIENT CONTACT.	☐	☐
8. THE APPLICANT HAS COMPLETED THE HOURS WHILE ENGAGED IN GRADUATE STUDY.	☐	☐
9. THE APPLICANT HAS GAINED KNOWLEDGE & EXPERIENCE WITH INDIVIDUALS FROM CULTURALLY/LINGUISTICALLY DIVERSE BACKGROUNDS AND WITH CLIENTS/PATIENTS OF ALL AGES.	☐	☐
10. THE APPLICANT HAS BEEN SUPERVISED BY INDIVIDUAL(S) HOLDING CURRENT/VALID ASHA CERTIFICATION OR LICENSURE IN SPEECH PATHOLOGY OR AUDIOLOGY.	☐	☐
11. THE AMOUNT OF SUPERVISION WAS APPROPRIATE TO THE STUDENT'S LEVEL OF KNOWLEDGE, EXPERIENCE & COMPETENCE, AND WAS SUFFICIENT TO ENSURE THE WELFARE OF THE CLIENTS.	☐	☐

I certify that all practicum information listed on this form was completed according to all ASHA and State of California practicum requirements.

SIGNATURE OF CURRENT TRAINING PROGRAM DIRECTOR IN BLUE INK

DATE SIGNED

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PRAXIS EXAMINATION INFORMATION

All applicants must submit a passing score on the required specialty examination. Your Praxis examination **must** be taken in the United States.

Audiology: Effective January 1, 2013, minimum passing score is **170**.

Speech-Language Pathology: Effective September 1, 2014 minimum passing score is **162**.

These examinations are offered at several sites throughout California and the United States, according to an annual schedule set by the Education Testing Service. Applications may be obtained from:

The Praxis Series
Educational Testing Service
P.O. Box 6051
Princeton, NJ 08541-6051
(609) 771-7395

The examination may be taken anytime within a 5 year period prior to filing an application for permanent licensure or it may be taken while the Required Professional Experience (temporary license) is being completed. As it takes approximately 6 weeks for ETS to process and send out scores, it is not recommended that you wait until the end of your RPE to sit for the examination. There are no limits on the number of times the examination may be taken.

When filing for the examination, arrange to have a copy of your score sent electronically to the Board office using the following Reporting Code: **R8544**

NOTE: As defined in the California Code of Regulations Section 1399.153.10 (a)" ……Under no circumstances will the Board reissue or extend a temporary license because of failure by the requestor, within the initial RPE Temporary License period, to submit the required licensing documentation or because of a failure by the requestor to take and pass the licensing examination as specified in Section 1399.152.3."

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REQUIRED PROFESSIONAL EXPERIENCE VERIFICATION FORM

INSTRUCTIONS AND IMPORTANT INFORMATION:

- This form must be completed and submitted within 10 business days after end date of experience, change in time base or end of supervision.
- Full-time and part-time experiences cannot be combined on the same form.
- Any corrections to this form must be crossed out and initialed by the Supervisor.
- Do **NOT** use white out or correction tape on this form.
- Do **NOT** fax or email this form to the Board.
- **SCHOOL SETTINGS:** Separate verifications and school calendars are required for each school session; including summer school.

PART A: RPE INFORMATION

1. FULL LEGAL NAME:	LAST	FIRST	MIDDLE
2. RPE LICENSE NUMBER			
3. STREET ADDRESS:			
CITY, STATE, ZIP CODE:			
4. EMAIL ADDRESS:			

PART B: SUPERVISOR INFORMATION

5. FULL LEGAL NAME OF SUPERVISOR:	LAST	FIRST	MIDDLE
6. SPEECH-LANGUAGE PATHOLOGY LICENSE NUMBER OR CLEAR CREDENTIAL NUMBER			
7. STREET ADDRESS:			
CITY, STATE, ZIP CODE:			
8. EMAIL ADDRESS:			

PART B: SUPERVISOR INFORMATION (Cont'd)

9. LOCATION(S) WHERE EXPERIENCE WAS OBTAINED:

CHECK ONE: ☐ SCHOOL SETTING ☐ OTHER

(A) _____
FACILITY OR SCHOOL NAME

_____
ADDRESS CITY, STATE, ZIP CODE

(B _____ **CHECK ONE:** ☐ SCHOOL SETTING ☐ OTHER
FACILITY OR SCHOOL NAME

_____
ADDRESS CITY, STATE, ZIP CODE

10. HOURS WORKED PER WEEK:

11. DATE OF EXPERIENCE: *(Must reflect only the dates AFTER the applicant was approved to start)* MM/DD/YYYY

START: / / END: / /

12. WILL THE APPLICANT CONTINUE TO WORK UNDER YOUR SUPERVISION?
If no supervision, RPE cannot practice until permanent license is issued.

☐ **YES** ☐ **NO**

13. SUPERVISION: *(Check One)*

☐ The RPE worked FULL-TIME, (30-40 hours per week) and I provided eight (8) hours of direct supervision per month. Four (4) of the eight (8) hours were in screening, therapy and evaluation.

☐ The RPE worked PART-TIME, (15-29 hours per week) and I provided four (4) hours of direct supervision per month. Two (2) of the four (4) hours were in screening, therapy and evaluation.

☐ The RPE worked less than fifteen (15) hours per week.

14. PERFORAMNCE OF RPE APPLICANT: *(Check One)*

☐ SATISFACTORY ☐ UNSATISFACTORY

COMMENTS: *(OPTIONAL)*

I declare under penalty of perjury under the laws of the State of California that I have discussed the foregoing with the applicant and that the statements made herein are true and correct, and I did not supervise more than two (2) other applicants obtaining their Required Professional Experience (RPE) during the same period of time. I further certify under penalty of perjury under the laws of the State of California that all statements made herein are true in every respect and that misstatements or omissions of material facts may be cause for denial of this verification, or for suspension or revocation of my license.

_____ _____
SUPERVISOR'S SIGNATURE DATE

_____
PRINT FULL LEGAL NAME OF SUPERVISOR

INFORMATION COLLECTION AND ACCESS

The Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board's Executive Officer is the person who is responsible for information maintenance. Section 2532 of the Business and Professions Code is the authority, which authorizes the maintenance of the information. All information is mandatory. Failure to provide any mandatory information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure. Each individual has the right to review his or her file maintained by the agency subject to the provisions of the California Public Records Act.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (checkone) ____Employment __X__License, Certification, Permit ____Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Speech Aide Audiology Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
Agency authorized to receive criminal history information

06187
Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100
Street No. Street or PO Box

N/A
Contact Name (Mandatory for all school submissions)

Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: Male Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: 7700 SLP/AU
OCA No. (Agency Identifying No.)

Level of Service DOJ X FBI X

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

BCII 8016 (Rev10/98) **ORIGINAL-Live Scan Operator; SECOND COPY-Requesting Agency; THIRD COPY-Applicant**

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (checkone) ___Employment __X__License, Certification, Permit ___Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Speech Aide Audiology Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

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N/A
Contact Name (Mandatory for all school submissions)

Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. **BIL -** _____
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ____ FBI ___

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

_____
Employer Name

_____
Street No. Street or PO Box

_____
Mail Code (five digit code assigned by DOJ)

_____
City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

_____ _____ _____
Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (checkone) ___Employment ___X___License, Certification, Permit ___Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Speech Aide Audiology Aide

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Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

HT: _____ WT: _____

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Name of Operator

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